The Massachusetts Guide To Health Insurance For People With Medicare

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January 1997

Disclaimer

The Division of Insurance and the Executive Office of Elder Affairs do not sell, recommend, promote, or endorse any insurance product, company or agent. The information in this guide is being provided to assist consumers in making informed purchasing decisions. Every effort has been made to ensure the accuracy of this information; however, some of the information may be subject to correction. This guide will be updated periodically.

Please note that this Guide only applies to policies sold in the Commonwealth of Massachusetts. To find out about policies which are sold in other states, you should refer to the Guide to Health Insurance for People with Medicare developed by the National Association of Insurance Commissioners and the federal Health Care Financing Administration. There will be information in that document about agencies to contact in other states about any special conditions that apply in that state.

Developed jointly by the
Division of Insurance
and the
Executive Office of Elder Affairs
of the Commonwealth of Massachusetts

The Massachusetts Guide To Health Insurance For People With Medicare

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Message to People in Massachusetts with Medicare

Buying health insurance for people with Medicare can be confusing. Reform measures in Massachusetts and at the federal level have led to many important changes for Medigap and Medicare HMO plans in Massachusetts.

"The Massachusetts Guide to Health Insurance for People with Medicare" answers the most often asked questions about Medigap and Medicare HMO plans in Massachusetts. There are a number of other informational resources, including other guides and pamphlets, that may be helpful to you. These resources are described in the section of this Guide entitled "Shopping Tips and How To Get Help." Also, there is a worksheet at the end of this Guide which may help you to compare plans.

We encourage you to read this Guide and the other available materials, and to discuss your needs with a family member or friends. If you have any questions about this type of insurance, you can call either the Massachusetts Executive Office of Elder Affairs at **1-800-882-2003** to speak with a SHINE (Serving Health Information Needs of Elders) counselor or the Division of Insurance Consumers HELP LINE at **(617) 521-7777** to speak with one of its representatives.

Commissioner of Insurance

Secretary of Elder Affairs

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The Medicare Program

- **What is Medicare?**

Medicare is a federal health insurance program for people age 65 and over, certain disabled people under age 65 and people with permanent kidney failure. The Medicare program is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health & Human Services (DHHS). The Social Security Administration (SSA) determines a person's eligibility for Medicare and collects Medicare premiums. At the state level, HCFA contracts with Blue Cross and Blue Shield of Massachusetts and the Aetna Insurance Company to process claims and pay providers of Medicare services.

For a more detailed explanation of the Medicare Program, you can call the Social Security Administration at **1-800-772-1213** to request a copy of **"The Medicare Handbook."** Please note that the rules that govern the Medicare program may change from time to time.

If you believe that you are **not** receiving the Medicare coverage that you are entitled to, you can call the Medicare Advocacy Project (MAP) at **1-800-323-3205** for information and help.

- **Who is eligible for Medicare?**

In general, you can qualify for Medicare if you are age 65 or older, a citizen or permanent resident of the United States and meet one of the following requirements:

- you receive benefits or are eligible to receive benefits (even as a spouse or widow or widower of an eligible person) under the Social Security or Railroad Retirement system; or

- you or your spouse had Medicare-covered government employment.

If you are under age 65, you may also qualify for Medicare if you have been a disabled beneficiary under the Social Security or Railroad Retirement system for more than 24 months.

Additionally, you may qualify for Medicare if you receive continuing dialysis for end-stage renal disease or if you have had a kidney transplant.

If you have questions about your eligibility for Medicare, you can contact the Social Security Administration at **1-800-772-1213**.

- **How do I enroll in Medicare?**

If you are already receiving Social Security or Railroad Retirement benefits when you turn 65, you will automatically receive a Medicare card in the mail. If you are not already receiving Social Security or Railroad Retirement benefits when you turn age 65, you can enroll for Medicare at your local Social Security or Railroad Retirement Office. If you have health insurance from your employer when you turn age 65, please read below in this Guide regarding health coverage from employer group plans for active employees and for retirees.

You can enroll for Medicare during your **initial** seven-month enrollment period that begins 3 months before the month in which you turn 65. After turning age 65, you can also enroll during the eight-month **special** enrollment period that begins with the month you or your spouse stops working or when you are no longer covered under the employer plan for active employees. If for some reason you miss the initial or special enrollment period, there is an annual **general** enrollment period from January 1 to March 31 with an effective date of the following July 1.

- **How much does Medicare cost?**

Medicare benefits are divided into two parts:

- Hospital Insurance -- Part A and
- Medical Insurance -- Part B.

Medicare Part A is premium-free if you meet the eligibility requirements. If you do not meet these requirements, you can purchase Part A by paying a monthly premium (you should contact the Social Security Administration for more information at **1-800-772-1213**).

Medicare Part B requires a premium payment of $43.80 per month for 1997. Failure to enroll in Part B during your initial Medicare enrollment period (except under specific conditions when you are covered by other health insurance) may result in a penalty of 10% of the Part B premium for every year that you could have enrolled but did not. (If you have questions about the Part B penalty, call the Social Security Administration at **1-800-772-1213.**) The premiums for Parts A and B will usually increase each January 1.

- **What does Medicare Hospital Insurance (Part A) cover?**

Medicare Part A covers the following medically necessary care subject to the deductibles and coinsurance amounts described below:

- Acute inpatient hospital care for up to 90 days per benefit period plus 60 lifetime reserve days
- Skilled care in a Skilled Nursing Facility following a 3-day hospital stay for up to 100 days per benefit period
- Inpatient care in a Psychiatric Hospital for up to 190 days in a person's lifetime
- Home health care
- Hospice care
- Blood after the first 3 pints

There is a hospital deductible of $760.00 **per benefit period** for 1997. You must pay this deductible before Medicare inpatient coverage begins. Once you pay the hospital deductible, Medicare will pay in full for up to the 60th day. If you stay in the hospital longer than 60 days, you are responsible for the daily coinsurance amount of $190.00 for the 61st to 90th days (which are renewable each benefit period). In addition, lifetime reserve days can help with your expenses if you need more than 90 days of inpatient care. These 60 additional days have a daily coinsurance amount of $380.00 and can only be used once. These deductibles and coinsurance amounts are the same for stays in Psychiatric Hospitals.

Medicare also pays in full for the first 20 days of covered Skilled Nursing Facility care. If you stay in the Skilled Nursing Facility longer than 20 days, you are responsible for the daily coinsurance amount of $95.00 for the 21st to 100th days (which are renewal each benefit period).

Here are some examples of out-of-pocket expenses under Medicare Part A depending on the hospital stay during 1997:

- Ms. Jones has Medicare Part A and is hospitalized for 70 days. For the first 60 days of her hospital stay, she would be responsible for the first $760 of the charges, which is called the Medicare Part A deductible. In addition to that, Ms. Jones would be responsible for $1,900 which represents the daily coinsurance for days 61-70 (10 days at $190 a day). Ms. Jones would have a bill of $2,660 for this hospital stay for Medicare Part A expenses; she may also have Medicare Part B expenses for the same stay.

- Ms. Jones has Medicare Part A and is hospitalized for 100 days. For the first 60 days of her hospital stay, she would be responsible for the first $760 of the charges. In addition, Ms. Jones would be responsible for $5,700, which represents the daily coinsurance for days 61-90 (30 days at $190 a day), and $3,800 which represents the daily coinsurance for lifetime reserve days 91-100 (10 days at $380 a day). She has now used 10 of her 60 lifetime reserve days. Ms. Jones would have a bill of $10,260 for this hospital stay for Medicare Part A expenses; she may also have Medicare Part B expenses for the same stay.

- **What does Medicare Medical Insurance (Part B) cover?**

Medicare Part B provides coverage for most of the following medically necessary care (this is not a complete list) subject to the deductible and coinsurance amounts listed below:

- Physician services
- Physical, occupational and speech therapies
- Certain ambulance services
- Outpatient hospital services
- Home health care if you do not have Part A
- X-rays and laboratory tests
- Durable medical equipment
- Blood (after the 1st three pints)
- Services of certain specially qualified practitioners who are not physicians.

You must pay the first $100 in Medicare-approved charges for covered medical services **each calendar year**. Once you have met the $100 deductible, Medicare Part B usually pays 80% of the Medicare-approved charges. **You are responsible for the remaining 20% Part B coinsurance.** However, if you receive outpatient services at a hospital, you are responsible for paying 20% of whatever the

hospital charges, not 20% of the Medicare-approved amount. Additionally, Medicare pays only 50% for the outpatient treatment of mental illness.

Here is an example of out-of-pocket expenses under Medicare Part B for a physician visit in 1997:

- Mr. Jones has Medicare Part B and is treated in his internist's office. The Medicare-approved amount for the visit is $250. Mr. Jones would be responsible for the first $100 (to meet his annual Part B deductible). Medicare would then pay $120 (80% of the $150 balance) and Mr. Jones would pay the remaining $30. The total bill for Mr. Jones would be $130. Mr. Jones has now met his $100 deductible and will not need to pay this again for any other Medicare Part B services received during 1995. [Note: if Mr. Jones had received Medicare-covered services for mental health care, instead of medical care, and the Medicare-approved amount was $250, he would be responsible for the first $100 (to meet the Part B deductible) and Medicare would pay only $75 (50% of the $150 balance). Mr. Jones would be responsible for the remaining $75 for a total of $175.]

Under Massachusetts law, a licensed physician cannot collect more than the Medicare-approved charge for any Medicare-covered service provided to a Medicare beneficiary. This type of law is often called a **"ban on balance billing."** For example, assume that Ms. Jones has already satisfied her calendar year Medicare Part B deductible of $100 and receives Medicare-covered services from her physician, for which her physician charges $150. If Medicare determines that the Medicare-approved amount for the service is $100, Medicare would pay $80 (80% of the $100). Ms. Jones is responsible for paying $20 (20% of the $100). The "ban on balance billing" law prohibits her physician from charging Ms. Jones an additional $50 (the amount above the $100 approved by Medicare).

You will note that under this law, a physician can charge you, or collect from your insurer, a copayment or coinsurance for Medicare-covered services. However, the physician cannot charge or attempt to collect from you an amount that, together with your copayment or coinsurance and any amount paid by your insurer, is greater than the Medicare-approved amount. Please contact the Board of Registration in Medicine at (617) 727-3086 if you believe that a physician is not complying with this law.

- **What health care services and items does Medicare not cover?**

Besides the deductible and coinsurance amounts described above, there are a number of other gaps in Medicare coverage. The following are examples of items not covered by Medicare (this is not a complete list):

- all charges for most self-administered drugs (including outpatient prescription drugs) and immunizations (except for pneumococcal, influenza and hepatitis B vaccinations)

- all charges for routine physicals and other screening services (except for mammograms and Pap smears for screening purposes, which are covered on a schedule set by Medicare)

- all charges for routine eye examinations or eyeglasses (except prosthetic lenses after cataract surgery)

- all charges for routine foot care except when a medical condition affecting the lower limbs requires care by a medical professional

- all charges for services of naturopaths, Christian Science practitioners, acupuncturists, immediate relatives, or charges imposed by members of your household

- all charges for most dental care and dentures

- all charges for hearing aids or routine hearing loss examinations

- all charges for care outside the United States and its territories, except in certain instances in Canada and Mexico

- all charges in excess of Medicare's maximum yearly payment of $900 for independent physical or occupational therapists

- custodial long-term care

As you can see from this list and what is identified on the next two pages, there are a number of gaps in Medicare coverage. Therefore, Medicare

beneficiaries need to look at other insurance products or other programs that are available to help them cover some of these health care costs.

MEDICARE (PART A): HOSPITAL INSURANCE COVERED SERVICES FOR 1997

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing, and other hospital services and supplies. (Medicare payment based on benefit periods; see page 43.)	First 60 days	All but $760	$760
	61st to 90th day	All but $190 a day	$190 a day
	91st to 150th day*	All but $380 a day	$380 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies.** (Medicare coverage based on benefit periods; see page 43.)	First 20 days	100% of approved amt	Nothing
	Additional 80 days	All but $95.00 a day	Up to $95.00 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services.	Unlimited as long as you meet Medicare requirements for home health care.	100% of approved amt; 80% of approved amt. for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited during a benefit period if medically necessary.	All cost except for first three pints per calendar year.	All costs for first three pints.***

* 60 reserve days may be used only once.

** Neither Medicare nor Medigap insurance will pay for most nursing home care.

*** To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

(Source: federal *1997 Guide to Health Insurance For People with Medicare)*

MEDICARE (PART B): MEDICAL INSURANCE COVERED SERVICES FOR 1997

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and other services.	Unlimited if medically necessary.	80% of approved amt (after $100 deductible); 50% of approved amt for most outpatient mental health care.	$100 deductible,* plus 20% of approved amount;** 50% for most mental health care.
CLINICAL LABORATORY SERVICES Blood Tests, urinalysis, and other laboratory services.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, and other services.	Unlimited if medically necessary.	100% of approved amt; 80% of approved amt for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of an illness or an injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital costs.	20% of whatever the hospital charges (after $100 deductible).*
BLOOD	Unlimited if medically necessary.	80% of approved amt (after $100 deductible and starting with fourth pint).	All costs for first 3 pints plus 20% of approved amount for add'l blood (after $100 deductible) ***

* Once you have had $100 of expense for covered services, Part B deductible does not apply to any other covered services received.

** State law prohibits physicians from collecting charges above the Medicare-approved amount.

*** To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

(Source: federal *1997 Guide to Health Insurance For People with Medicare)*

Health Insurance for People With Medicare

- **What types of private health insurance fill Medicare's gaps and/or replace Medicare coverage?**

As discussed in the previous section of this Guide, Medicare has deductibles, coinsurance and other limitations that leave significant gaps in its coverage. Therefore, you are responsible for paying these uncovered medical expenses. There are a variety of ways to fill many of Medicare's gaps through private health insurance, including:

- a Medigap plan
- a Medicare Health Maintenance Organization (HMO) plan
- health coverage from an employer group plan for active employees
- health coverage from an employer group plan for retirees

- **What is a "Medigap" plan?**

A Medigap plan (also known as Medicare supplemental insurance) is specifically designed to supplement Medicare benefits. Medigap plans may pay for many of the gaps that Medicare does not cover including deductibles and coinsurance amounts, and may pay for some services not covered by Medicare. However, Medigap plans do not cover all the Medicare gaps.

- **What is a Medicare Health Maintenance Organization (HMO) plan?**

Instead of buying a Medigap plan, you may decide to enroll in a Health Maintenance Organization (HMO) that has a contract or agreement with Medicare. These Medicare HMOs provide Medicare benefits, cover the Medicare deductible and coinsurance amounts, and may cover other services (including benefits you cannot get through a Medigap plan). Most Medicare HMOs will charge you small copayments when you receive certain services from the HMO. Like Medigap plans, Medicare HMO plans do not cover all the Medicare gaps.

You may receive certain benefits through a Medicare HMO that you cannot get through Medicare or through Medigap plans currently being sold in Massachusetts, including routine physicals and unlimited inpatient acute hospital days. In addition, some Medicare HMO plans have benefits for eye exams and eyeglasses, dental care and hearing exams.

Medicare HMOs provide benefits through a network of physicians, hospitals and other health care professionals. Outpatient services are usually provided at one or more centrally located facilities or in a physician's or other health care provider's private office. In most circumstances, HMO enrollees may obtain services only from HMO providers or providers outside the HMO network only with the HMO's approval. However, for Medicare beneficiaries who purchase a Medicare HMO plan, the **type of arrangement** that the HMO has with Medicare will affect how much coverage there will be for Medicare benefits if the Medicare beneficiary goes outside the HMO network for **non-emergency** services.

Medicare HMOs that have a **Risk Contract** with Medicare (see Glossary for definition) have "lock-in" requirements. This means that you are locked into receiving all covered care, **including most Medicare benefits**, through the HMO, or through referrals by the HMO. If you go outside the HMO for services, neither the HMO nor Medicare will pay for those services, with few exceptions, and you will have to pay the entire bill out of your own pocket. The only exceptions are for emergency services, which you may receive anywhere in the United States, and urgently needed care, which you may receive while temporarily away from the HMO's service area.

Medicare HMOs that have a **Cost Contract** with Medicare or that have **Health Care Prepayment Plan (HCPP) agreements** with Medicare (see Glossary for definitions) do not have the same lock-in requirements for Medicare-covered services as the HMOs with Risk Contracts. If you enroll in an HMO that has a Cost Contract or HCPP agreement and you receive **non-emergency** services within the United States from providers outside the HMO network, without the HMO's approval, Medicare will pay its portion but the HMO plan will pay nothing. This means that you will be responsible for the charges not covered by Medicare, including deductible and coinsurance amounts. Emergency services, as well as urgently needed services that you receive while temporarily away from the HMO's service area, which are received outside the HMO network of providers, are covered according to Medicare rules.

You can receive a copy of a pamphlet called **"Medicare Managed Care"** by contacting the Social Security Administration at **1-800-638-6833** for more information on Medicare HMOs.

Please note that there are no approved HCPPs available for sale for new individual coverage starting on or after January 1, 1996.

- **What should I know about health coverage from an employer group plan for active employees?**

You may be able to obtain health insurance coverage through your current employer.

- If you or your spouse are age 65 or older and continue to work for an employer who has 20 or more employees, the employer is required, by law, to offer you and your spouse the same choice of health care plans, under the same conditions, as those offered to employees under age 65.

- If you choose the employer health plan, the employer plan will be the primary payer. When the employer plan is the primary payer, Medicare is the secondary payer. This means that the employer plan will pay first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services.

Even if you are covered under an employer health plan, you should consider enrolling in Medicare Part A upon turning age 65. You may decide **not** to enroll in Medicare Part B at this time, depending on the coverage you may have under your employer group health plan (check with the Social Security Administration **at 1-800-772-1213** or a SHINE (Serving Health Information Health Needs of Elders) health insurance counselor who can be reached through the Executive Office of Elder Affairs **at 1-800-882-2003**.

- **What should I know about health coverage from an employer group plan for retirees?**

When you retire, you may be offered a retiree health plan through your employer. Employer group insurance plans that supplement Medicare are not required to comply with the regulations governing Medigap plans sold to individuals. You may want to consult with a SHINE counselor before deciding whether to keep a retiree health plan or purchase a Medigap or Medicare HMO plan.

- **Can I buy a Medigap or Medicare HMO plan if I already have some type of health coverage either through my employer or purchased on my own?**

Most individuals enrolled in Medicare need only one Medigap policy or Medicare HMO plan. Recent changes in the federal law have altered the situations under which an individual can purchase more than one plan. The following examples describe situations under which you can or cannot purchase more than one plan.

If you have a Medigap policy and then decide to enroll in a Medicare HMO plan, you may either keep the Medigap policy or, if you decide you like the Medicare HMO plan, you may cancel the Medigap policy. In general, you will not need a Medigap policy if you are enrolled in a Medicare HMO plan. If you enroll in a Medicare HMO plan with a Risk Contract, a Medigap policy will likely be of little or no value. This is because if you go outside the HMO network for Medicare-covered services, neither Medicare nor a Medigap policy will pay benefits. If you enroll in a Medicare HMO plan with a Cost Contract or HCPP agreement, it is advisable to get all of your services through the HMO's network since you may already be paying a premium and would probably only incur copayments. However, if you expect to go outside the HMO network for many services, a Medigap policy might cover the deductibles and coinsurance amounts you will incur, depending on the Medigap policy that you select.

Until recently, Medigap insurers would have been prohibited from selling you a Medigap policy if you were already enrolled in a Medicare HMO plan because it would duplicate benefits that you were getting through the plan. However, this is no longer true. However, please review the above paragraph to help you decide if you really need a Medigap policy if you are already enrolled in a Medicare HMO plan.

You do not need more than one Medigap plan that you buy on your own. If you choose to replace your current policy with a different Medigap policy, you must sign a statement indicating that you are replacing a policy and will not keep both policies. Do not cancel your old policy until the new one is in force and you are sure that you will keep it after the thirty-day free look period. (For more information on the thirty-day free look period for Medigap plans, please read the section of this Guide entitled "What to Look for and How To Get Help.")

Until recently, it was illegal for an insurer to sell you a Medigap policy if it would duplicate other benefits you had under another policy such as an active employee health plan or a retiree health plan. This is no longer true. You may now be sold a Medigap plan even if it duplicates your retiree health plan benefits, and the Medigap plan must pay full benefits even if the retiree plan also pays for the same service. Your retiree plan may contain a coordination of benefits clause; if it does, the retiree plan will not pay duplicate benefits.

- **How does federal law affect Medigap and Medicare HMO plans and what kinds of changes have occurred at the federal level?**

Beginning in 1992, federal law required all states to standardize and simplify Medigap policies sold in the United States to individuals. Therefore, in almost every other state, there are ten different plans that can be sold (usually referred to as Plans A through J).

However, because Massachusetts had a unique program for Medigap plans, it received a waiver from implementing all the federal plans except for Plan A. **Don't be confused by information about plans being sold in other states.** It is important that you know what benefit plans are available in Massachusetts. A chart explaining the three standard Massachusetts Medigap plans that can now be sold for coverage beginning on or after January 1, 1995, follows this section of the Guide.

The federal government approves and monitors the HMOs that offer plans for people with Medicare. There are also state laws and regulations that apply to Medicare HMO plans. The Massachusetts Division of Insurance oversees Medicare HMO plans in Massachusetts, in addition to the oversight provided by the federal government.

- **What state reforms apply to Massachusetts Medigap and Medicare HMO plans?**

As of January 1, 1995, the reforms that apply to Medigap and Medicare HMO plans include the following:

- **Three Standard Medigap Plans:** As noted above, there are three standard Massachusetts Medigap plans that can be sold for coverage beginning on or after January 1, 1995:

    - Medicare Supplement Core;

    - Medicare Supplement 1 (no outpatient prescription drug coverage); and

    - Medicare Supplement 2 (outpatient prescription drug coverage with $35 deductible per calendar quarter--100% covered for generic drugs and 80% covered for brand-name drugs--no maximum limit for drug benefit).

- **Required Drug Benefits:** All Medigap insurers must sell both the Medicare Supplement Core and the Medicare Supplement 2 plans. HMOs that want to sell plans to people with Medicare are required to sell a plan that has outpatient prescription drug coverage that is similar to the drug benefit required for the Medicare Supplement 2 plan. Along with the drug plan, Medicare HMOs may also sell a product without prescription drug coverage, but they are not required to do so.

- **Community Rating:** Medigap insurers and Medicare HMO plans are required to charge one rate to consumers regardless of the person's age or person's health. They may charge a rate based on where you live. Under Massachusetts regulations, this is called **community rating**.

- **Open Enrollment Periods:** All Medigap insurers and Medicare HMOs are required to make their plans available to most people with Medicare during an open enrollment period held from February 1 to March 31 each year. The new rules also expand the other times that plans must be made available to most people with Medicare. In addition, Medigap and Medicare HMO plans are allowed to have continuous open enrollment throughout the year.

The next page of this Guide contains a chart which outlines the three standard Massachusetts Medigap plans, and the following section has additional information that you need to know about Medigap and Medicare HMO plans in Massachusetts.

- **Can I buy a Medicare SELECT product in Massachusetts?**

Medicare SELECT was designed by Congress to be an experimental program in 15 designated states. Medicare SELECT products are just like regular Medigap products except each Medicare SELECT insurer has doctors and hospitals that you must use, except in an emergency, to receive full benefits. Congress originally approved the Medicare SELECT program availability through December 31, 1994, extended it once through June 30, 1995 and recently extended it for at least three more years and to all 50 states.

Massachusetts became a designated state after the program had already been started in the original 15 states but chose not to implement Medicare SELECT at that time because the experimental program was due to end and had not been extended for any significant length of time. However, the Division of Insurance is currently reviewing how it may implement Medicare SELECT in Massachusetts.

Three Standard Massachusetts Medigap Plans: Available in Massachusetts for Coverage Beginning on or After January 1, 1995

Standard Benefits	MEDICARE SUPPLEMENT CORE	MEDICARE SUPPLEMENT 1	MEDICARE SUPPLEMENT 2
Basic Benefits: • Part A Hospital Coinsurance	X	X	X
• 365 Lifetime Hospital Days	X	X	X
• First three pints of blood each year	X	X	X
• Part B Medical Coinsurance (generally - 20% for all approved services)	X	X	X
Coverage in addition to Medicare for inpatient days in licensed mental health hospitals	60 Days per calendar year less Medicare or plan days	120 Days per benefit period less Medicare or plan days	120 Days per benefit period less Medicare or plan days
Skilled Nursing Facility Coinsurance (Days 21-100)		X	X
Part A Deductible		X	X
Part B Deductible		X	X
Foreign Travel		X	X
Outpatient Prescription Drugs Purchased at Retail Pharmacies: $35 calendar quarter deductible-- Generic drugs: 100% Brand-name drugs: 80%			X

Note: Look at each company's materials to find out what benefits, if any, the company has added to the standard benefits for each plan it offers.

Additional Information That You Need to Know About Medigap and Medicare HMO Plans in Massachusetts

- **Who sells approved Medigap or Medicare HMO plans?**

The Addendum to this Guide has a list of the approved Medigap and Medicare HMO plans that can be sold in Massachusetts as of the date the Addendum was prepared. The Addendum has important information such as: the address and phone number for the approved Medigap insurers and Medicare HMOs, plan names, premiums, drug benefits, discount programs and open enrollment times. The Addendum will be updated as new plans are approved or other information changes.

Please note that some Medigap insurers only sell their plans to members of certain association groups and do not sell their plans to individuals who are not members of those groups. For example, some elder groups may work with a Medigap insurer to offer these Medigap plans to its members. The Addendum to this Guide tells you whether the Medigap insurer sells its plans only to members of certain association groups.

- **Which of the three standard Medigap plans cover outpatient prescription drugs?**

Only the Medicare Supplement 2 plan covers outpatient prescription drugs that you buy at a pharmacy. As discussed above in this Guide, all Medigap insurers in Massachusetts must offer the Medicare Supplement 2 plan.

The outpatient drug benefit in the Medicare Supplement 2 plan has a $35 deductible for each calendar quarter (i.e., January through March; April through June; July through September; and October through December) and pays 80% for brand name drugs and 100% for generic drugs. The total dollar amount of coverage that you can receive under this drug benefit is unlimited.

Some Medigap insurers may require that you buy your prescription drugs from pharmacies that are in the insurer's pharmacy network. You should ask the insurer about this type of requirement when choosing a plan.

As discussed below, some Medigap plans may also have a mail-order program through which you can order outpatient prescription drugs.

- **Which Medicare HMO plans cover outpatient prescription drugs?**

Massachusetts now requires each Medicare HMO to sell a plan that covers outpatient prescription drugs.

The Medicare HMO drug benefit can have a copayment amount of up to $8 for generic drugs and $15 for brand name drugs **or** a copayment amount of up to $10 for both generic or brand name drugs. Some Medicare HMOs may have different copayment amounts depending on whether you buy the drugs at one of their health centers or at a pharmacy, or based on the number of days for which the drug is prescribed. Like Medigap plans, the total dollar amount of coverage that you can receive under this drug benefit is unlimited.

As discussed below, some Medicare HMO plans also may have a mail order program through which you can order outpatient prescription drugs.

- **Do any of the Medigap or Medicare HMO plans pay for outpatient prescription drugs that I order through the mail?**

A Medigap insurer may offer a mail-order program for outpatient prescription drugs with its Medicare Supplement 2 plan but it is not required to do so. Also, a Medicare HMO may offer a mail-order program for outpatient prescription drugs with its drug plan but is not required to do so. The Medigap insurer or HMO may limit the mail order companies from which you can order the drugs. The Addendum to this Guide tells you which Medigap and Medicare HMO plans have a mail-order program for outpatient prescription drugs. You should contact the Medigap insurer or HMO directly to find out more about this type of program.

- **Who Can Buy a Medigap Plan and When Can They Buy It?**

In Massachusetts, in most cases, a Medigap insurer cannot refuse to insure you because of your health or age; however, you can only apply during an open enrollment time and you must meet the other requirements listed below. Also, if you are enrolled in the Medicaid or QMB (Qualified Medicare Beneficiary) programs, there are special federal laws regarding whether you can be sold a Medigap plan. For more information on those laws, please see the section of this Guide entitled "Health Insurance for People with Medicare."

Open Enrollment for People Who are "Initially Eligible for Coverage": Under Massachusetts rules, people who qualify as an "eligible person" and are "initially eligible for coverage" as defined below get a six-month open enrollment period for Medigap plans from the date they become "initially eligible for coverage." People who meet these requirements can buy any approved Medigap plan sold by an insurer in Massachusetts without further health screening and regardless of age.

You are an "eligible person" if you are eligible for Medicare Part A and B and are enrolled (or about to enroll) in Medicare Part B, regardless of age, with one exception: Medigap insurers can refuse to accept people who are under age 65 and on Medicare only because of end-stage renal disease.

You become "initially eligible for coverage" when:

(1) you first enroll in Medicare Part B at any age; or
(2) you have lost health insurance coverage from your employer because your job ends or your employer stops offering health coverage to employees like you; or
(3) you are covered by an HMO but move out of the HMO's service area; or
(4) you become a Massachusetts resident.

Please read below in this Guide to learn about premium discounts and surcharges involving enrollment when initially eligible for coverage.

Open Enrollment for People Who Are Turning 65 Or Who Are Age 65 Or Older When They Enroll in Medicare Part B: If you are eligible for Medicare Part A and B, for a period of six months from the date you are both enrolled in Medicare Part B and are age 65 years or older, you can buy any Medigap plan sold by an insurer that is approved to sell Medigap plans in Massachusetts regardless of any health problems you may have. People who enroll

under these circumstances are also considered "initially eligible for coverage" under Massachusetts rules.

Annual Open Enrollment Period: In Massachusetts, there is an annual open enrollment period from February 1 through March 31. During the annual open enrollment period, any person who qualifies as an "eligible person" can buy any approved Medigap plan sold by an insurer in Massachusetts without further health screening and regardless of age ("eligible person" is defined above in the section concerning open enrollment for people "initially eligible for coverage"). Coverage will begin the following June 1 or when Medicare coverage is first effective if this will happen before June 1. (HMO plans for people with Medicare also participate in this annual open enrollment period. The open enrollment rules for Medicare HMO plans are described below in this Guide.)

Other Open Enrollment Periods: Some Medigap insurers may have open enrollment periods during other times of the year or all year long (continuous open enrollment). The Addendum to this Guide lists which insurers have these kinds of open enrollment periods.

Open Enrollment for People Who Are Under Age 65 and on Medicare for Any Disability Other Than End-Stage Renal Disease: Under Massachusetts requirements, people who are under age 65 and on Medicare for any disability other than end-stage renal disease can buy a Medigap plan if they become "initially eligible for coverage," or during an annual open enrollment period or during any other open enrollment period that a Medigap insurer has, as discussed above.

Along with the Massachusetts open enrollment periods, these individuals get a six-month open enrollment period under federal requirements when they turn age 65. This six-month open enrollment period begins on the first day of the month in which they turn 65, unless their birthday is on the first of the month, in which case it begins the first day of the preceding month. After turning 65, these people can still rely on the Massachusetts open enrollment times.

Open Enrollment for People Who Are Under Age 65 and on Medicare Only Because of End-Stage Renal Disease: People under age 65 and on Medicare only because of end-stage renal disease get a six-month open enrollment when they turn age 65, as required by federal law. This six-month open enrollment period begins on the first day of the month in which they turn 65, unless their birthday is on the first of the month, in which case it begins the first day of the

preceding month. After turning 65, under Massachusetts rules, people in this situation can also apply for a Medigap plan if they become "initially eligible for coverage," or during an annual open enrollment period or during any other open enrollment period that a Medigap insurer has scheduled, as discussed above.

- **Who Can Buy a Medicare HMO Plan and When Can They Buy It?**

If you want to enroll in a Medicare HMO plan that has a Risk or Cost Contract with Medicare, you must meet the following four requirements: (1) you must live in the plan's service area; (2) you must have Medicare Part B; (3) you do not have permanent kidney failure; and (4) you have not elected the Medicare hospice benefit. You should note that if you have permanent kidney failure, and you are currently enrolled in a non-Medicare HMO plan, you will be able to convert to that HMO's plan for people with Medicare. For more information on this option, you should contact your HMO plan.

If you want to enroll in a Medicare HMO plan that has a Health Care Prepayment Plan (HCPP) agreement with Medicare, you must have Medicare Part B (federal requirement), live in the plan's service area (Massachusetts requirement), and meet any of the other eligibility requirements for that plan under federal or Massachusetts requirements.

Open Enrollment for People Who are "Initially Eligible for Coverage": People who (1) meet the eligibility requirements for the plan in which they are enrolling and (2) qualify as "initially eligible for coverage" under Massachusetts rules, get a six-month open enrollment period for Medicare HMO plans from the date they become "initially eligible for coverage." People who meet these requirements can buy any approved plan sold by an HMO in Massachusetts for people with Medicare without further health screening and regardless of age.

You become "initially eligible for coverage" under Massachusetts rules when:

(1) you first enroll in Medicare Part B at any age; or
(2) you have lost health insurance coverage from your employer because your job ends or your employer stops offering health coverage to employees like you; or
(3) you are covered by an HMO but move out of the HMO's service area; or
(4) you become a Massachusetts resident.

Please read below in this Guide to learn about premium discounts and surcharges involving enrollment when initially eligible for coverage.

Open Enrollment for People Who Are Turning 65 Or Who Are Age 65 Or Older When They Enroll in Medicare Part B: Under federal rules, if you are enrolled in a regular HMO plan (not designed for people on Medicare) for the month immediately before the month in which you are entitled to Medicare Parts A and B or Part B only, you may be able to convert to the HMO's plan for people with Medicare. For more information on this option, you should contact your HMO plan.

Annual Open Enrollment Period: In Massachusetts, there is an annual open enrollment period from February 1 through March 31. During the annual open enrollment period, all the approved HMO plans for people with Medicare are available for sale and can be purchased if the applicant meets the plan's eligibility requirements without further health screening and regardless of age. Under federal rules, coverage will begin no more than 90 days from the date you apply; you will have three options for your coverage starting date. (Medigap insurers also participate in this annual open enrollment period. The rules for Medigap insurers are described above in this Guide.)

Other Open Enrollment Periods: Some Medicare HMO plans may have open enrollment periods during other times of the year or all year long (continuous open enrollment). The Addendum to this Guide lists which Medicare HMO plans have these open enrollment periods. Please note that HMOs are allowed to limit the time during which members without a drug plan may upgrade to a drug plan to just the February/March open enrollment period described above.

Open Enrollment for People Who Are Under Age 65 and on Medicare for Any Disability Other Than End-Stage Renal Disease: Under Massachusetts rules, people who are under age 65 and on Medicare for any disability other than end-stage renal disease can buy a Medicare HMO care plan if they (1) meet the eligibility requirements for the plan in which they are enrolling and (2) either become "initially eligible for coverage" or during an annual open enrollment or any other open enrollment period that the plan has, as discussed above. After turning 65, these people can still rely on the Massachusetts open enrollment times.

Open Enrollment for People Who Have End-Stage Renal Disease: Under federal rules, people who have end-stage renal disease cannot enroll in an HMO

plan for people with Medicare that has a Risk or Cost Contract with Medicare. However, as discussed above, if you have permanent kidney failure, and you are currently enrolled in a non-Medicare HMO plan, you will be able to convert to that HMO's plan for people with Medicare. For more information on this option, you should contact your HMO plan.

- **Can Medigap or Medicare HMO plans have waiting periods or exclude benefits because I have pre-existing medical conditions?**

No. The Medigap and Medicare HMO plans that are sold for coverage to begin on or after January 1, 1995, in Massachusetts cannot have waiting periods or refuse to provide you with certain benefits even if you have pre-existing medical conditions or because you take prescription drugs or because you were recently hospitalized.

- **How much will a Medigap or Medicare HMO plan cost me?**

The Addendum to this Guide gives the approved premium rates for each Medigap and Medicare HMO plan.

- **Who decides how much a Medigap or Medicare HMO plan will cost?**

The premium rates for Medigap plans are reviewed by the Massachusetts Commissioner of Insurance. Some Medigap rate requests may require that a hearing be held by the Commissioner. For example, if a Medigap insurer requests a rate increase of ten percent or more, Massachusetts law requires that a hearing be held by the Commissioner.

The premium rates for Medicare HMO plans for people with Medicare are reviewed by both the federal government and the Massachusetts Commissioner of Insurance. If the Medicare HMO plan has a Cost Contract or has a HCPP agreement with Medicare and requests a rate increase of ten percent or more, Massachusetts law requires that a hearing be held by the Commissioner, as is required for Medigap plans.

- **Will I pay a higher premium because of my age or health condition?**

If you buy a Medigap plan so that your coverage starts on or after January 1, 1995, the insurer cannot charge you a premium based on your age or health

condition. However, Medigap companies may charge you a different premium amount based on where you live. Medicare HMO plans do not charge premium based on your age or health condition. HMOs, like Medigap plans, may charge premium based on where you live.

Please note that the Addendum to this Guide describes whether the Medigap or Medicare HMO plan charges premium based on where a person lives.

- **Are there any premium discounts for Medigap or Medicare HMO plans?**

Under Massachusetts regulations, a Medigap insurer or HMO that has a Cost Contract or HCPP agreement with Medicare may offer a premium discount program for people who enroll for coverage during the six-month open enrollment period when they are "initially eligible for coverage" after they turn age 65, as defined by Massachusetts regulations.

Discounts offered cannot be greater than 15% per year and may not be applied for more than three years from the time you first receive coverage. Each annual discount is to be applied against the premium for that year. The specifics of each discount program may differ and must be approved by the Commissioner of Insurance.

The Addendum to this Guide notes whether the Medigap insurer or Medicare HMO has a premium discount program. You should contact the insurer or HMO directly to learn the details of its program.

- **Will I pay a higher premium if I don't purchase a Medigap or Medicare HMO plan when I am initially eligible for coverage or if I change to a plan with more benefits?**

Under Massachusetts regulations, a Medigap insurer or HMO that has a Cost Contract or HCPP agreement with Medicare may have a premium surcharge program beginning in 1997, but it is not required to have such a program. If an insurer or HMO has a surcharge program then it must also have a discount program.

A premium surcharge is applied to people who are either late enrollees or people who upgrade coverage.

A late enrollee is someone who did not apply for Medigap insurance or a Medicare HMO plan within six months of when they became "initially eligible for coverage," unless the person meets three requirements: (1) the person was covered under a health plan for at least three years prior to the time of application; (2) the coverage for the previous health plan does not end more than 30 days before the start of the Medigap or Medicare HMO Cost Contract plan; and (3) the benefits of the previous health plan are similar to the Medigap or Medicare HMO Risk or Cost Contract plan that the person wants to enroll in.

An individual upgrades coverage when he/she has a Medigap or HMO Cost Contract or HCPP plan but wants to switch to a different Medigap plan or HMO Risk or Cost Contract or HCPP plan that has more benefits and the two plans are not similar. These people are often called "upgraders."

Any surcharge cannot be greater than 15% per year. Surcharges may not be applied for more than three years from the time you first receive coverage under the plan with more benefits, and each annual surcharge is to be applied against the premium for that year. The specifics of each surcharge program may differ and must be approved by the Commissioner of Insurance.

People who are upgrading from a plan that was issued before January 1, 1995, cannot be surcharged during the annual open enrollment period held in 1997.

Special Information for People Who Bought a Medigap or Medicare HMO Plan for Coverage Beginning Before January 1, 1995

If you bought a Medigap or Medicare HMO plan with coverage starting before January 1, 1995, you will be able to keep that plan in most cases. However, you may want to consider switching to either a Medigap or Medicare HMO plan that is currently approved for sale in Massachusetts.

In particular, if you want a plan that has unlimited outpatient prescription drug coverage, you should note that all Medigap insurers and Medicare HMO plans must now offer one plan that covers outpatient prescription drugs and the plan cannot limit the total amount of coverage you receive for those drugs.

People who bought a Medigap policy for coverage starting before January 1, 1995, should also consider the following information. Your insurance carrier may charge you a premium based on your age when you bought your policy or based on your current age. However, Medigap policies sold on or after January 1, 1995, cannot charge a premium based on age, and Medicare HMO plans do not charge based on age.

It is suggested that you study this entire Guide to help you decide whether you want to change plans. Also, before changing plans, compare benefits and premiums between plans. (There is a worksheet at the end of this Guide which may help you to compare plans.) The policy benefits in the plans that are being sold on or after January 1, 1995, may be different from the benefits in your current plan. Keep in mind that the plan you have now may no longer be approved for sale in Massachusetts and, therefore, you may not be able to switch back if you change your mind after canceling your current plan.

Finally, if you decide that you want to change plans, you can do so during any allowed open enrollment periods that apply to your situation. Open enrollment periods are explained in more detail in the section of this Guide entitled "Additional Information That You Need to Know About Medigap and Medicare HMO Plans in Massachusetts."

Other Programs for Health Care Coverage

- **I cannot afford to pay the premiums for Medicare or a Medigap or Medicare HMO plan. What other programs are available that can help me?**

There are a variety of programs available, including:

- the standard Medicaid program
- the Qualified Medicare Beneficiary program (QMB)
- the Specified Low-Income Medicare Beneficiary program (SLMB)
- Federally Qualified Health Centers
- the Senior Pharmacy program
- the CommonHealth program
- the Uncompensated Care Pool
- drug company programs

The Standard Medicaid Program: The standard Medicaid program is a state and federal health insurance program that purchases medical services for eligible Massachusetts residents who cannot otherwise afford health care. You may be eligible if your income and assets are within certain limits and you are: pregnant; under 18; responsible for a related dependent child who lives with you; aged 65 or over; or disabled.

In 1996, you may be eligible for the standard Medicaid program if your monthly income is not more than $665 per month for an individual and $884 per month for a couple and your assets (not including your house or car) do not exceed $2,000 for one person or $3,000 for a couple. (Please note that 1997 amounts will be announced in March 1997.)

If you are entitled to both Medicare and standard Medicaid benefits, an insurance company cannot sell you a Medigap plan unless the state pays the premiums for you and the insurer allows the state to pay your premium. However, if you purchased a Medigap plan after November 4, 1991, and then become eligible for Medicaid, you can request that the Medigap benefits and premiums be suspended for up to two years while you are covered by Medicaid. Should you become ineligible for Medicaid benefits during the two year period, your Medigap

policy will be reinstated if you give proper notice and begin paying premiums again. You may want to discuss your options with your local Medicaid Case Worker.

The Qualified Medicare Beneficiary (QMB) Program: The QMB program will pay the Medicare Part A & B premiums, deductibles and coinsurance. In 1996, to be eligible, your monthly income cannot be more than $665 per month for an individual and $884 per month for a couple and you cannot have assets (not including your house or car) of more than $4,000 for an individual and $6,000 for a couple. **A Medigap insurer can sell a Medigap plan to a person enrolled in the QMB program only if the Medigap plan pays for outpatient prescription drugs.** Currently, the only Medigap plan that can be sold in Massachusetts that covers outpatient prescription drugs is the Medicare Supplement 2 plan.

The Specified Low-Income Medicare Beneficiary (SLMB) Program: The SLMB program will pay the Medicare Part B premium only. In 1996, to be eligible, your monthly income cannot be more than $794 per month for an individual and $1,056 per month for a couple and you cannot have assets (not including your house or car) of more than $4,000 for an individual and $6,000 for a couple. **A Medigap insurer can sell any approved Medigap plan to a person enrolled in the SLMB program.**

If you think you might be eligible for the standard Medicaid program or the QMB or SLMB programs, contact the Division of Medical Assistance at **1-800-841-2900**.

Federally Qualified Health Centers: Another option that can help limit your health care costs is to receive health services at a Federally Qualified Health Center (FQHC). Medicare pays for some health services that are not otherwise Medicare-covered services, such as preventive care services, when they are provided by an FQHC, including: routine physical examinations, screening and diagnostic tests for the detection of vision and hearing problems and administration of certain vaccines.

You do not have to pay the $100 Medicare Part B deductible for services provided at a FQHC. While the Part B coinsurance applies to all FQHC services, guidelines allow FQHCs to waive it in some instances. Any Medicare beneficiary may seek services at a FQHC. To find out whether one of these centers serves your area, call **1-800-638-6833**.

Senior Pharmacy Program: This is a new state program that will be administered by the Executive Office of Elder Affairs in cooperation with the Department of Medical Assistance. Eligible individuals may receive up to $500 per year for certain prescription drugs. In order to qualify, an individual must meet the following requirements:

- be age 65 or older as of July 1, 1997
- be a resident of the state for the last 6 months
- cannot be enrolled in the Medicaid program
- cannot have drug coverage from supplemental policy or other third party payor
- must have income no greater than 133% of federal poverty level ($10,294/year)

The open enrollment period is scheduled for February and March at which time individuals can apply for the program. Coverage will begin on July 1 each year. At the end of January, individuals can contact their local Home Care Corporation for information on the application process. For information on how to contact your local Home Care Corporation, you can call the Executive Office of Elder Affairs at 1-800-882-2003.

The CommonHealth Program: This state program provides health care benefits to disabled working adults and disabled children. Call the CommonHealth Program at the Division of Medical Assistance at **1-800-662-9996**.

The Uncompensated Care Pool: Hospitals are required to provide certain people with free care in their facilities. Call your local hospital or the Division of Health Care Policy and Finance at **(617) 451-5330**.

Drug Company Programs: More than 50 drug companies offer **free** prescription drugs to people of all ages who qualify. Each drug company has different guidelines. To obtain a list of the drugs that are covered and a sample application form, please call Mass Home Care's Elder Line at **1-800-243-4636**.

What to Look for and How to Get Help

- **What should I keep in mind when purchasing a Medigap or Medicare HMO plan?**

  - It is important that you understand what Medicare does and does not pay for first. Remember that **no** plan fills in all the gaps.

  - Take the time to assess your medical needs.

  - Before buying any additional insurance, you should (1) review any insurance that you already have, such as employer-paid coverage, to see what, if any, additional insurance you need and can afford; and (2) if you have a low income and limited resources, check to see whether you qualify for the standard Medicaid program or any other program to help in paying your health care costs.

  - Know with whom you are dealing. Keep agents' and/or companies' names addresses and telephone numbers.

  - Compare several different plans.

  - **Don't buy more policies than you need.**

  - Make sure you understand the benefits of a plan, when the plan will become effective, and how much the plan will cost. Some Medigap insurers may use "brand names" along with the standard plan names; when you look at an insurer's Medigap policies, be sure you know which standard plan is being described.

  - Ask if the plan has a toll-free number for you to call with any questions.

  - Don't be rushed into choosing a Medigap plan. You are entitled to a 30-day free look period. This means that if for any reason you do not want the Medigap plan, you have 30 days to cancel the policy and receive a full refund.

- Decide carefully whether you will pay your Medigap premium on a monthly, quarterly, semi-annually or annual basis, depending on the options offered by the Medigap insurer. After the 30-day free look period, Medigap insurers are only required to return the unearned premium upon your death if you pay your premium on a quarterly, semi-annual or annual basis. However, each Medigap insurer is required to inform applicants regarding whether or not it will return unearned premium if the policy is canceled after the 30-day free look period for a reason other than death and premium is paid on a quarterly, semi-annual or annual basis.

- **Pay by check** made out to the Medigap insurer or HMO, **not by cash**.

- **How can I learn more about a particular Medigap insurer or HMO and the plans it offers?**

You should contact the Medigap insurers and HMOs if you want to learn more about the plans that they offer. You can ask for information from the agent, broker or service representative of a Medigap insurer or HMO. Medigap insurers should give you a document that is called an "Outline of Coverage." The "Outline of Coverage" has information about the three standard Medigap plans, as well as other important general information. You should carefully examine an insurer's materials to find out which plans it sells and what benefits are in each plan.

Also, you can talk to your friends, relatives, neighbors, etc., about their experiences with a Medigap insurer or HMO. Your local public library may have books that provide financial and other information about the Medigap insurers that are commercial insurance companies.

- **Where else can I go for help or questions about health insurance for people with Medicare?**

The Executive Office of Elder Affairs (EOEA) has a health insurance counseling program called the SHINE (Serving Health Information Needs of Elders) program. SHINE counselors are volunteers, mostly elders, who receive training in many areas of health benefits. A SHINE counselor can assist you in understanding your health insurance needs, help review your present coverage, help process health claims, inform you of your rights and make appropriate referrals if necessary. To find a local SHINE counselor in your area, contact EOEA at **1-800-882-2003.**

In addition, you can contact the Division of Insurance (DOI) Consumer HELP LINE at **(617) 521-7777**. DOI can provide the most updated list of approved plans.

- **What other guides and pamphlets are available and how can I obtain them?**

There are a number of guides and pamphlets that can provide you with more information than is contained in this Guide, many of which are noted above in the Guide. The list is as follows (mailing addresses follow this list):

1. "The 1997 Guide To Health Insurance for People with Medicare," (developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services) and the "Massachusetts Attachment" to that guide (developed jointly by the Division of Insurance and the Executive Office of Elder Affairs of the Commonwealth of Massachusetts). It may be obtained from health insurers or HMOs or by writing to the Executive Office of Elder Affairs or the Division of Insurance.

2. "The Medicare Handbook" (May be obtained by calling the Social Security Administration at **1-800-772-1213**.)

3. "Medicare Managed Care" (May be obtained by calling the Social Security Administration at **1-800-772-1213** or **1-800-638-6833**.)

4. "A Consumer's Guide to Long Term Care Insurance" (May be obtained by writing to the Executive Office of Elder Affairs or the Division of Insurance.)

5. "AIDS and Health Insurance: Take Charge of Your Health!" (May be obtained by writing to the Division of Insurance.)

6. "You *Can* Take It With You: Continuation of Group Insurance Coverage" (May be obtained by writing to the Division of Insurance.)

7. "A Consumer's Guide to Nursing and Rest Homes" (May be obtained by writing to the Executive Office of Elder Affairs.)

8. "Assisted Living in Massachusetts: A Consumer's Guide" (May be obtained by writing to the Executive Office of Elder Affairs.)

Mailing Addresses For the Executive Office of Elder Affairs and Division of Insurance:

Information and Referral
Executive Office of Elder Affairs
One Ashburton Place, 5th Floor
Boston, MA 02108

Health Policy Section
Division of Insurance
470 Atlantic Avenue
Boston, MA 02210-2223

- **What can I do if I have concerns about insurance agents, brokers, insurers or HMOs when I am shopping for health care coverage?**

The majority of insurance agents, brokers and companies are highly ethical. A few, however, are not. If you believe that an agent, broker or company has treated you unfairly, please contact the Division of Insurance Consumers HELP LINE at **617-521-7777** or write to the Division of Insurance at 470 Atlantic Avenue, Boston, MA 02210-2223.

An insurance agent, broker or insurer or HMO representative **should not**:

- Object to your taking notes or object to a relative or friend being present.
- Decline to show you his or her credentials.
- Claim a policy pays 100% of everything Medicare doesn't pay.
- Fail to explain the policy to you or answer questions completely.
- Suggest you drop a policy you already have in order to buy the policy he/she is selling without a detailed explanation of why you would be better off with the policy he/she is selling.
- Discourage you from shopping around or checking out the policy thoroughly before deciding to buy the policy.

- Continue to persist after you have said you do not want further discussion or contact.

- Try too hard to convince you of the possibility of becoming bankrupt if you don't purchase a policy.

- Insist or pressure you to pay a full year's premium at the time of application.

Glossary

Assignment: An arrangement whereby a physician or medical supplier agrees to accept the Medicare-approved amount as full payment for services and supplies covered under Part B. If the physician or supplier chooses not to accept assignment, Medicare beneficiaries are responsible for paying any excess, except in Massachusetts for physician services.

Benefit Period: A benefit period begins on the day you enter a hospital or skilled nursing facility and ends when you have been out of the facility for 60 days in a row without being readmitted.

Coinsurance: The portion or percentage of the Medicare-approved amount that a Medicare beneficiary is responsible for paying.

Community Rating: A rating methodology under current Massachusetts regulations by which the premium for all persons covered by a particular Medigap plan or Medicare HMO plan with a Cost Contract or HCPP agreement is the same, based on the experience of all persons covered by the plan, without regard to age, sex, health or occupation. This rating methodology was implemented in Massachusetts for these plans as of January 1, 1995. Medicare HMO plans with a Risk Contract also have community rating.

Cost Contract: A type of contract that a Health Maintenance Organization (HMO) may have with Medicare which allows you to receive Medicare-covered services outside the HMO network. If you receive non-emergency services within the United States outside the network without the HMO's approval, Medicare will pay its portion but the HMO plan will not pay any amount.

Deductible: The amount of expense a Medicare beneficiary must first incur before Medicare begins payment for covered services.

Group Model of Health Maintenance Organization (HMO): An HMO arrangement in which the HMO contracts for services to be provided by existing medical group practices. Group practices usually provide services to HMO members as well as other patients.

Guaranteed Renewable: A policy provision for Medigap policies whereby the insured has the right to continue the Medigap policy in force by the timely payment of premiums and the Medigap insurer has no unilateral right to make any change in any provision of the policy or rider(s) while the insurance is in force other than changes in premiums, and cannot cancel or decline to renew, except for the non-payment of premium or material misrepresentation by the insured; provided that Blue Cross and Blue Shield of Massachusetts shall not be required to continue the coverage of a policyholder who becomes a resident of a state other than Massachusetts.

Health Care Prepayment Plan (HCPP): A type of agreement that an HMO may have with Medicare which allows you to receive Medicare-covered services outside the HMO network. If you receive non-emergency services outside the network within the United States, Medicare will pay its portion but the HMO plan will not pay any amount.

Health Maintenance Organization (HMO): An organized system for providing comprehensive health care services to a voluntarily enrolled population in a geographical area in return primarily for a fixed periodic prepaid fee (premium). In Massachusetts, HMOs are licensed under Massachusetts General Laws chapter 176G. The HMO employs and/or contracts with health care providers to furnish services to its enrollees. In most circumstances, enrollees may obtain services only from, or with the approval of HMO providers. However, for Medicare beneficiaries, the type of arrangement that the HMO has with Medicare will affect how much coverage you will have for Medicare benefits if you go outside the HMO network for non-emergency services. Emergency services, as well as urgently needed services, that you receive within the United States while temporarily away from the HMO's service area, which are received outside the HMO network of providers are covered according to Medicare rules.

Home Health Care: Skilled health care provided in your home for the treatment of an illness or injury.

Independent Practice Association (IPA) Model of Health Maintenance Organization (HMO): An arrangement whereby the HMO contracts with associations of doctors in the community who treat HMO members out of their own private offices, as well as other patients.

Lifetime Reserve Days (nonrenewable): The 60 additional Medicare days you can use if you remain hospitalized for more than 90 days. These additional lifetime reserve days can only be used once.

Medicare: A federal health insurance program for persons 65 and older and certain disabled people. The program is administered by the Health Care Financing Administration (HCFA).

Medicare Carrier: An insurance organization under contract to the federal government to process Medicare Part B claims from physicians and other suppliers.

Medicare Intermediary: An insurance organization under contract with the federal government to process claims from hospitals, skilled nursing facilities, home health care agencies, hospices and certain other providers of Medicare Part A services.

Pre-existing Condition: A condition for which medical advice was given or treatment was recommended by or received from a physician within a specified period before the effective date of coverage.

Risk Contract: A type of contract that an HMO may have with Medicare that requires enrollees to receive all covered care, including Medicare-covered services, through the HMO plan; with few exceptions, if you go outside the plan for services, neither the HMO plan nor Medicare will pay for those services.

Skilled Nursing Facility (SNF): A specially qualified facility that has staff and equipment to provide skilled nursing care, rehabilitation services, and other related health services.

Staff Model of Health Maintenance Organization (HMO): An HMO arrangement in which the HMO delivers services at a facility owned and operated by the HMO. The physicians are on the HMO staff and usually only see HMO members.

Worksheet to Compare Massachusetts Plans

Plans sold prior to 1995 may or may not have benefits found in standard Medigap or Medicare HMO plans available on or after January 1, 1995.

	Policy 1		Policy 2		Policy 3
Medicare Part A: Hospitalization					
Part A Deductible					
Hospital Coinsurance for Days 61-90					
Hospital Coinsurance for Days 90-150					
Coverage for 365 Days After Medicare					
Skilled Nursing Facility Coinsurance for Days 21-100					
First 3 Pints of Blood					
Medicare Part B: Medical Expenses					
Part B Deductible					
20% of Medicare Approved Services					
Other Expenses:					
Foreign Travel					
Prescription Drug - Retail Pharmacy					
Prescription Drug - Mail Order					
Routine Physicals					
Routine Office Visits/Exams					
Eye wear/Eyeglasses					
Hearing Aids					
Dental Benefits					
Services and Conditions:					
Community Rating					
Age-rate Premiums					
Guaranteed Renewable					
Lifetime Maximum Benefit					
Guaranteed Issue					
Company with Toll-Free Number					
Offers Crossover Claims Filing					
Premiums and Additional Costs:					
Monthly Premium					
Office Visit Copayment					
Prescription Drug - Retail Copayment					
Prescription Drug - Mail Order Copayment					